Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Replaces VHA Directive 99-005, and VHA Directive 2002-020

VHA DIRECTIVE 2002-023

April 12, 2002

AMBULATORY CARE DATA CAPTURE

NOTE: *This VHA Directive rescinds VHA Directive 2002-020, dated April 8, 2002.*

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides guidelines for ambulatory care data capture.

2. BACKGROUND

a. Since October 1, 1996, VHA facilities have been required to report all electronic data concerning the provision of services in VHA facilities, to include each ambulatory encounter and/or ancillary service, in accordance with the data element definitions provided in this directive. When available, VHA is to utilize data definitions for clinical and administrative data promulgated by internationally and nationally recognized standard setting organizations (e.g., American Society for Testing and Materials, American National Standards Institute (ANSI), American Health Information Management Association (AHIMA), etc.).

b. VHA's decision support system (DSS) utilizes DSS outpatient identifiers to represent DSS work units or DSS products. The DSS Program Office is responsible for maintaining and nationally distributing the list of stop codes and DSS identifiers (see the current VHA Directive on DSS).

c. **Definitions**

(1) The following definitions apply to ambulatory care data:

(a) Licensed Practitioner. A licensed practitioner is an individual at any level of professional specialization who requires a public license and/or certification to practice the delivery of care to patients. A practitioner can also be a provider (see subpar. 5b).

(b) Non-licensed Practitioner. A non-licensed practitioner is an individual without a public license or certification who is supervised by a licensed and/or certified individual in delivering care to patients (see subpar. 5b).

(c) Provider. A provider is a business entity that furnishes health care to a consumer; it includes a professionally licensed practitioner who is authorized to operate a health care delivery facility (see subpar. 5b).

NOTE: *For VHA purposes, a Department of Veterans Affairs (VA) medical center, to include its identified divisions and community based outpatient clinics (CBOCs), is considered to be the business entity furnishing health care at the organizational level. Sub-organizational-level entities by which data needs to be retrievable include parent and community site, specific clinics (regardless of site may have more than one type of DSS identifier and stop code, for example an*

CBOC), treatment team, and individual practitioner. A Centers for Medicare and Medicaid Services (CMS)) Person Class field is reported together with the VA medical center and VA medical center division code to the National Patient Care Database (NPCD).

(d) Encounter**.** An encounter is a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating and/or treating the patient's condition (adapted from subpar. 5b).

1. Contact can include face-to-face interactions or those accomplished via telemedicine.

2. Use of e-mail will be limited and will not constitute an encounter at this time. As e-mail communications are not secure, e-mail will not contain patient specific information. In the future, when secure methods of e-mail communication for health care are widely used to ensure privacy and security of patient information, inclusion of e-mail interactions between patients and providers should be re-evaluated. E-mail will not be used to communicate urgent matters.

3. By definition, encounters are neither occasions of service (see subpar. 2c(1)(e)) nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, etc. Activities that are an integral part of an encounter are not to be reported in a separate encounter. A patient may have multiple encounters per visit ((see subpar. 2c(1)(g)).

4. There must be a primary DSS identifier assigned to a clinic. Secondary identifiers can be used in certain instances. The DSS identifier(s) for a clinic must meet the definitions outlined in DSS Directive. ***NOTE:*** *Refer to the current DSS Identifier Directive for guidance.* Overall, the DSS identifier needs to depict the primary workgroup responsible for the clinic and/or the type of services normally provided during an appointment. Each site is to ensure that the set up of the clinic profile and DSS identifier(s) is confirmed with the local DSS staff, and accurately reflect the health care members for that clinic, i.e., the physician, the nurse, the dietitian, the social worker, etc. Workload and data accuracy requirements necessitate accurate reporting of encounters. ***NOTE:*** *When additional encounters are created to capture work that is already included within a patient encounter, unnecessary duplication of work is created and dilution of workload as well as costs occur, which affects DSS, the Revenue Office, Performance Measurement, data accuracy, etc.*

5. For VHA purposes, a telephone contact between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter, namely history and medical decision-making. Telephone encounters must be associated with a telephone clinic that is assigned one of the DSS telephone three-digit identifiers. Telephone encounters are to be designated as non-billable.

6. Telemedicine Services. Telemedicine is generally described as the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including: cost efficiency, reduced

transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers. For VHA purposes, a telemedicine contact between a practitioner and a patient is only to be considered an encounter if the specifics outlined in subparagraph 2c(1)(e) are met. Telemedicine encounters must be designated with the appropriate secondary DSS Identifier of 690 unless the program is specifically for Tele-home care, DSS ID 179, with credit pair 690.

7. Collateral services provided, as a part of the patient's care (such as family therapy) are not to be reported separately. Collateral services provided directly to the collateral (for example, to the spouse) separate from the patient must be reported separately for the collateral, i.e., stress reduction skills.

8. DSS identifiers must be updated annually to appropriately identify encounters.

(e) Occasion of Service. An "occasion of service" is a specified identifiable instance of an act of technical and/or administrative service involved in the care of a patient or consumer which is not an encounter; that is, does not include the exercise of independent medical judgment in the overall diagnosing, evaluating and/or treating the patient's condition (s) (adapted from subpar. 5f).

1. Occasions of service are the result of an encounter (e.g., tests or procedures ordered as part of an encounter). Clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring are all examples of occasions of service.

2. A patient may have multiple occasions of service per encounter.

3. Some occasions of service, such as clinical laboratory and radiology studies and/or tests, are automatically loaded to the patient care encounter (PCE) database from other Veterans Health Information Systems and Technology Architecture (VistA) packages.

4. DSS identifiers will be updated annually to appropriately identify occasions of service.

5. Occasions of service replace the previously used term "ancillary services."

(f) Workload Only. Situations may exist which are "workload only." That is, they meet neither the definition of an encounter nor an "occasion of service." "Workload only" clinics need to be set to non-count and non-billable. These are tracked for workload only (internal use), and are neither an encounter nor an "occasion of service." ***NOTE:*** *Refer to the current DSS Identifier Directive to appropriately identify workload only DSS identifiers.*

(g) Visit. With the changes across VHA in providing services to veterans across the continuum of care, the definition of "visit," used for the purpose of reporting services provided to a veteran and/or patient in a 24-hour period, has been revised to reflect more specificity at the provider level.

1. The previous definition of visit reflected patient activity at the level of the parent facility; i.e., the visit of an outpatient to one or more units or facilities located in or directed by the

provider maintaining the outpatient health care services (clinic, physicians office, hospital and/or medical center) within 1 calendar day.

2. The revised definition of visit has been changed to reflect patient encounters at the provider level; i.e., the visit of an outpatient to one or more units located in or directed by the provider maintaining the outpatient health care services within 1 calendar day at the facility level including the station number and the suffix identifiers (i.e., for facilities, visits are to be reported at the three-digit station level, for visits reported; for instance, at CBOCs it must include the suffix (STA5A)).

(2) In addition to the current administrative data elements, such as eligibility, period of service and service related condition information, patient address, next of kin, etc; the minimum clinical data elements required to constitute an encounter or occasion of service are as follows:

(a) Patient**.** The person receiving health care services.

1. VistA. The full name, date of birth, Social Security Number (SSN) or pseudo-SSN, eligibility, etc.

2. NPCD. The full name, date of birth, Social Security Number (SSN) or pseudo-SSN, eligibility, etc.

(b) Date and Time of Service. The actual date and time that the encounter or service was scheduled to occur. Time is a single entry indicating the time that the encounter was scheduled to occur. This data element is taken from the Appointment Scheduling software. The data element will be identical in VistA and NPCD, but only reported when services are actually provided, (e.g., when the appointment is checked out, when the laboratory test is performed, etc.).

(c) Practitioner. See the definition in preceding paragraphs 2c(1)(a), 2c(1)(b), and 2c(1)(c). VistA will store practitioner information from the Person Class file for an individual or designated group. Each practitioner must be designated with a defined practitioner type from the Person Class file, such as physician, nurse practitioner, physician assistant, etc. Practitioner type is to be stored in NPCD.

1. The Person Class file provides seven trainee categories. These may be added as secondary providers, however the supervising practitioner is to be recorded as the primary provider (see VHA Directive 2000-015, Person Class Taxonomy).

a. 24 V111300 Physicians (Doctor of Medicine (M.D.) and (Doctor of Osteopathy (D.O.)) -- Intern, Allopathic

b. 25 V111400 Physicians (M.D. and D.O.) -- Intern, Osteopathic

c. 144 V115500 Physicians (M.D. and D.O.) -- Resident, Allopathic

d. 145 V115600 Physicians (M.D. and D.O.) -- Resident, Osteopathic

e. 209 V030300 Dental Service -- Dental Resident

f. 333 V070802 Nursing Service -- Other Nursing Services (non-registered nurse (RNs)) -- Graduate Nurse

g. 396 V130405 Respiratory, Rehabilitative and Restorative Service -- Rehabilitation Practitioner - Rehabilitation Intern

2. Resident person class assignments should be limited to the two resident classifications and not reflective of the teaching physician specialty.

a. 144 V115500 Physicians (M.D. and D.O.) -- Resident, Allopathic

b. 145 V115600 Physicians (M.D. and D.O.) -- Resident, Osteopathic

(d) Place of Service. Information about the location where the service was provided. In both VistA and NPCD, this will include the three-digit medical center and/or station identifier, with any applicable suffixes (STA5A), as well as the DSS Identifier(s). In the future, place of service will include the five-character medical center national VHA division value. The division value must reflect the location where care was provided.

(e) Active Problems (purpose of visit). Problem and/or diagnosis(es) treated that relate to the encounter (International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes). When more than one active problem or diagnosis is designated for an encounter, the practitioner must determine which one is the primary reason the patient sought treatment at that encounter. The determination of whether or not a treatment was related to an adjudicated service connected condition or treatment of conditions related to exposure and/or experience for (Agent Orange, Ionizing Radiation, or Environmental Contaminants) will be based on all conditions treated during the encounter and the entire encounter will be designated service connected or designated as being in a special related to the special categories, if any treatment related to these conditions was provided. VistA maintains and stores text descriptions along with coded values. Only the coded values are to be transmitted to NPCD.

NOTE: *Guidelines published by the American Hospital Association, ICD-9-CM, and the National ICD-9-CM Coding conventions and guidelines must be followed for ICD-9-CM code assignment.*

(f) The Service Provided. Services provided to the patient by the practitioner or provider must be fully supported by medical documentation. Only nationally accepted coding schemes, such as full Correct Procedural Terminology (CPT)-4 codes including modifiers, when appropriate, and Healthcare Common Procedural Coding System (HCPCS) Level II codes are to be used to reflect all services provided by applicable practitioners. VistA maintains and stores text descriptions along with the coded values. Only the coded values are transmitted to NPCD.

1. Guidelines published by the American Medical Association (AMA) must be followed for CPT-4 code assignment.

NOTE: *Use of evaluation and management (E & M) codes require that certain criteria be met within the coding guidelines. Those practitioners licensed and privileged within the scope of their practice or licensure may limit the use of many E & M codes.*

2. Guidelines published by the CMS must be followed for HCPCS Level II code assignment and for assignment of approved Level III codes. Code assignment must depict services rendered and documented.

3. POLICY: It is VHA policy to collect ambulatory care data to support the continuity of patient care, resource allocation, performance measurement, quality management, research, and third-party payer collections.

4. ACTION

a. **Network Directors.** Network Directors must ensure that the Patient Information Management System (PIMS) and Patient Care Encounter (PCE) software packages are maintained on all medical centers' VistA systems in accordance with nationally distributed software and software patches.

b. **Facility Directors and facility Chiefs of Staff**

(1) Facility Directors and facility Chiefs of Staff must ensure that clinical staff document clinical information in conformance with medical center documentation policies and by-laws, and in a format that conforms to the software requirements for defining the practitioner; the patient's active problems, diagnosis(es) or reason for visit; and, the service provided to the patient. The facility Director must ensure that staff accurately documents patient demographics, the date and time of service, and the place of service in conformance with the requirements of the software. Facility Directors must also ensure that facility staff continue to maintain, on each clinic set up in the Scheduling Package, a DSS Identifier or credit pair (if appropriate) as the work group associated with that clinic set up.

(2) Where encounter forms, like those from the Automated Information Collection System (AICS), are used as a tool to manage the collection of coded information manually or on data collection screens, facility Directors must ensure that data validation is performed to ensure that only valid codes are used on all encounter forms. Regular maintenance of these forms is required at least twice each year. The nationally approved codesets are changed twice annually each year generally on October 1 and January 1, releases of CPT, HCPCS and ICD-9-CM coding changes. Trained and competent coding staff must perform data validation of the coded information in accordance with the data validation requirements of the facility. The data on the encounter forms must conform to the definitions and conventions included in the appropriate coding methodologies noted in paragraph 3.

(3) Encounter data is transmitted to the NPCD at the Austin Automation Center, Austin, TX. The local facility Directors are responsible for general monitoring of the transmission of encounter data is at regular intervals through the use of the Ambulatory Care Report Program (ACRP) Transmission report, Outpatient Activity Report (OPA) reports, messaging mail groups

for transmission status, checking the logical link for the HL7 messages, and checking the transmission queue. ***NOTE:*** *See Attachment A details on monitoring and validating transmission of workload data to NPCD.*

(4) Facility Directors and facility Chiefs of Staff must ensure the use of PIMS and PCE software packages; such use is mandatory. Use of AICS software is encouraged, but not mandatory. To transmit ambulatory encounters, or occasions of service data, to NPCD, the necessary data elements must be stored in PCE and must be entered via the software capture methods prescribed (scheduling, PCE, AICS, Event Capture System, Radiology, Laboratory, etc.); but must have a patient assigned to a clinic. Use of the AICS manual data entry option requires an encounter form be established for the clinic, but does not require that the encounter form(s) be printed in advance.

5. REFERENCES

a. American Medical Association. Common Procedural Terminology (CPT-4).

b. American Society for Testing and Materials. (1999). E1384-99: Standard Guide for Content and Structure of the Electronic Health Record (EHR). West Conshohocken, PA:

c. CMS. HCPCS Level II and Level III Codes.

d. National Committee for Vital and Health Statistics. Uniform Ambulatory Medical Care Minimum Data Set.

e. World Health Organization. ICD-9-CM.

f. Youman, K.G. (2000). Basic Healthcare Statistics for Healthcare Information Management Professionals. Glossary. Chicago, IL: American Health Information Management Association (AHIMA).

g. VHA Directive 2000-015.

6. FOLLOW-UP RESPONSIBILITY: Director, Information Assurance Office (19F), is responsible for the content of this Directive.

7. RESCISSIONS: VHA Directive 96-057, and VHA Directive 2002-020 are rescinded. This VHA Directive expires May 31, 2005.

Robert H. Roswell, M.D.
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 4/12/2002
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 4/12/2002

ATTACHMENT A

INSTRUCTIONS FOR
INFORMATION RESOURCES MANAGEMENT (IRM) STAFF TRANSMITTING WORKLOAD TO THE NATIONAL PATIENT CARE DATABASE (NPCD)

1. Ambulatory Care Nightly Transmission to NPCD Option. Ensure that the option Ambulatory Care Nightly Transmission to NPCD [SCDX AMBCAR NIGHTLY XMIT] is scheduled to run on a daily basis, as this is the background job that generates the AmbCare HL7 messages. After each completion of this job, a summary bulletin stating the number of encounters included in the HL7 messages is sent to members of the mail group assigned to the SCDX AMBCARE TO NPCDB SUMMARY bulletin.

2. Systems Link Monitor Option. Using the option Systems Link Monitor [HL MESSAGE MONITOR] ensure the following:

a. At least one incoming filer is running.

b. At least one outgoing filer is running.

c. The AMB-CARE logical link is running (STATE column lists IDLE).

d. Values in the MESSAGES RECEIVED and MESSAGES PROCESSED columns for the AMB-CARE logical link increase on a daily basis.

e. Values in the MESSAGES TO SEND and MESSAGES SENT columns for the AMB-CARE logical link increase on a daily basis.

3. Logical Link Possibilities

a. The HL7 outgoing filer is probably not running if the MESSAGES TO SEND for the AMB-CARE logical link does not increase and the Ambulatory Care Nightly Transmission to NPCDB job has run. If this happens, use the option Monitor, Start, Stop Filers [HL FILER MONITOR] to start an outgoing filer.

b. The HL7 incoming filer is probably not running if the MESSAGES RECEIVED for the AMB-CARE logical link continues to increase while the MESSAGES PROCESSED does not. If this happens, use the option Monitor, Start, Stop Filers [HL FILER MONITOR] to start an incoming filer.

c. It is highly likely that the AMB-CARE logical link is not running if the MESSAGES TO SEND for the AMB-CARE logical link continues to increase while the MESSAGES SENT does not. If this happens, use the option Start and Stop Links [HL START] to stop and then start the AMB-CARE logical link.

4. Using the option Transmission History Report - Full [SCDX AMBCAR XMIT HIST FULL], generate the ACRP TRANSMISSION HISTORY report for previous days. This report lists all

the encounters transmitted to Austin during a given time frame and includes whether or not an acknowledgement was received. Acknowledgements are usually received within 2 days of transmission and if you are not seeing the acknowledgements it is highly likely that something is not running and all AmbCare and HL7 background processes should be checked.

5. Monitor the OPA reports coming from Austin to ensure that they reflect receipt of data. Not seeing receipt of data in Austin via these reports indicates something is not running and all AmbCare and HL7 background processes should be checked.